AGO Advisory Task Force on Community Benefits: Meeting 2

MAY 22, 2017

HEALTH CARE DIVISION
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Agenda

1. Advisory Task Force Goals & Process
2. Presentation on DPH's CHI Program, Including Updated Health Priorities
3. Discussion of Role of AGO Guidelines in Encouraging Meaningful, High Impact Investments in Documented Health Priorities

Advisory Task Force Goals and Process

Assessing Community Health Need

Meeting 2 (May 22)

Coordinating Responsive Investments

Meeting 3 (June 28)

Reporting, Evaluation & Learning

Meeting 5 (Sept 5)

Community Engagement

Meeting 4 (July 24)

Financial Assistance/Debt Collection Policies

Meeting 6 (Oct 18)

Review Working Draft of Updated Guidelines

Meeting 7 (Nov 20)

Agenda

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Commonwealth of Massachusetts
Department of Public Health

Revision of the Determination of Need Regulation 105 CMR 100.000

AGO Advisory Task Force on Community Benefits
May 22, 2017

Outdated and Outmoded

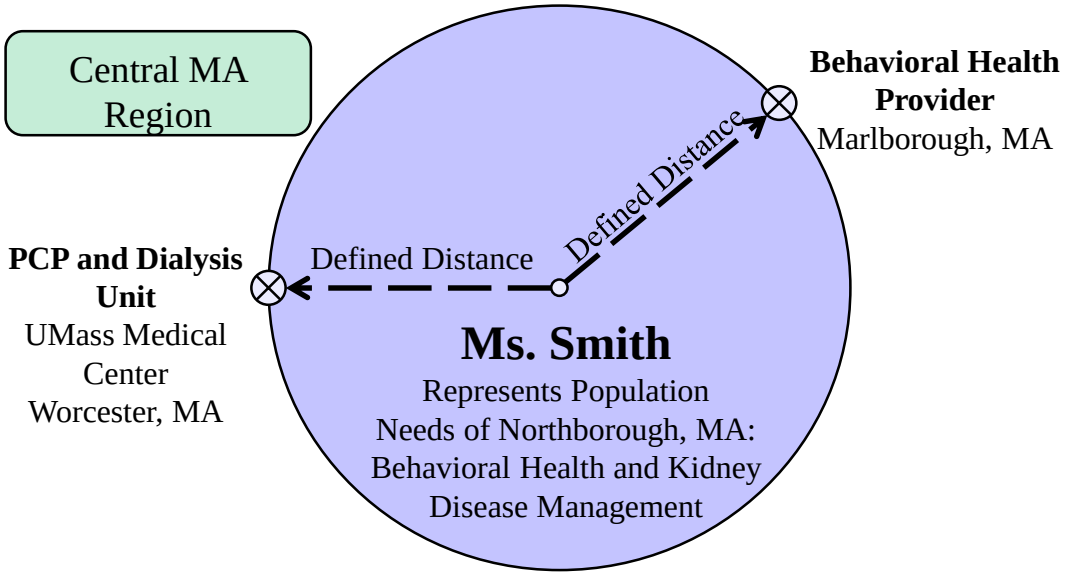
- **Problem Statement:** Created in 1971 by the MA Legislature, MA's DoN regulation has been outpaced by a rapidly evolving healthcare market and currently does not align with DPH's core mission.

- **1971:** DoN established.
  - ✓ ***Providers:*** Care largely provided in standalone, not-for-profit hospitals or small group practices.
  - ✓ ***Payment:*** Fee-for-service or cost-based reimbursement. Rate setting commission set public rates.
  - ✓ ***DON:*** Played a critical role in protecting MA from state overspending on new technologies and duplicative services. Goal was to prevent saturation through non-duplication of services.

- **2016:** Post-Chapter 224 and ACA health reform.
  - ✓ ***Providers:*** Significant provider consolidation. Complex health systems that closely control patient referral patterns. Increased reliance on innovation through technologies and services.
  - ✓ ***Payment:*** Systems taking on increased risk and no government rate setting.
  - ✓ ***DON:*** Objective has been the non-duplication of services, rather than incentivizing competition on basis of value. Increasingly out of alignment with DPH mission (*i.e.* population health) and state goals for delivery system transformation.

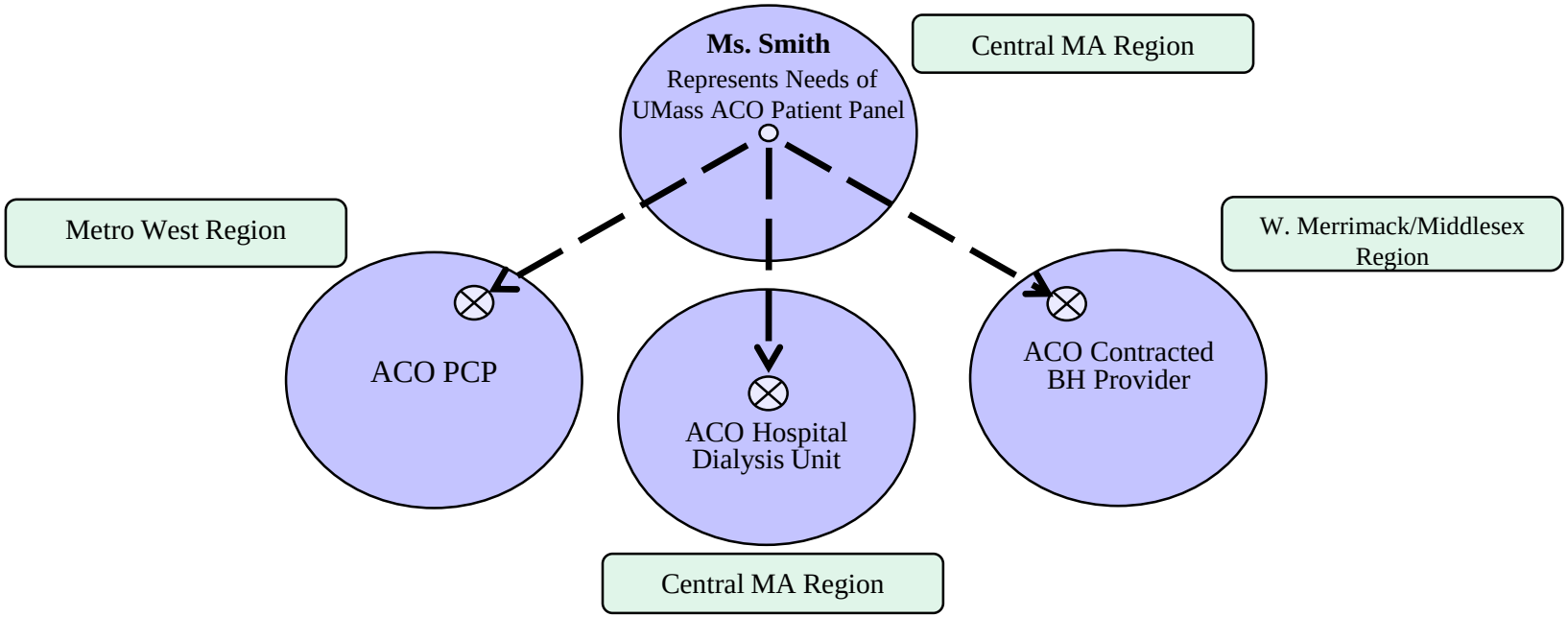
- **Result:** Despite these substantial changes in health care over the past 45-years, due to regulatory stagnation, DoN has become outdated and outmoded.

Traditional Health Planning (1970-2012)



- ❑ **Map population health needs** of defined, limited geographic area
- ❑ **Measure excess/scarcity** of needed services within area
- ❑ **Historical role of DoN:**
  - ✓ To allow government to ***monitor and control costs*** of large projects and new technologies (era of rate setting and cost-based reimbursement)
  - ✓ To empower government to ***regulate excess/scarcity*** through geographic distribution of services

Potential ACO View of Future Role of DoN and Health Planning

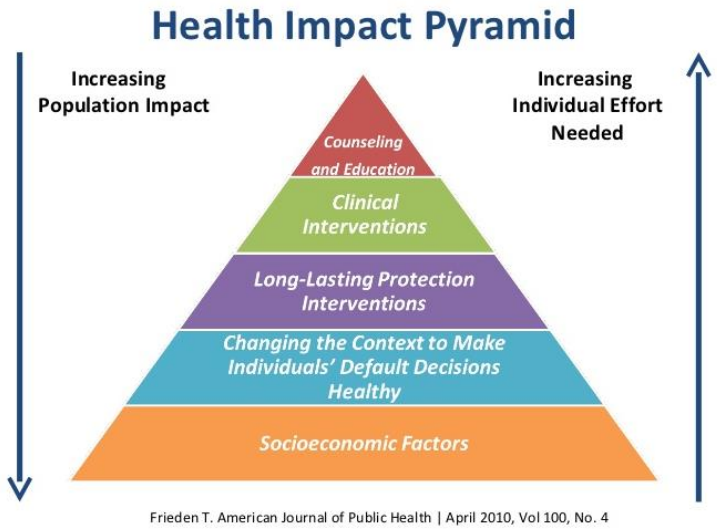


- **ACO "owns" patient risk** – question for ACO is how to best manage risk by ensuring access to needed services at lowest cost
- **ACOs could argue that DoN not needed** as ACOs will be best situated – and at risk – to manage and plan for the needs of their patient panel
- **Question is access to services within the system**, not excess/scarcity within a defined geographic area

False Choice

- **Neither scenario is reflective of today's health care market**.
- **No health care system today represents an ACO that is fully "at-risk"** – largely definitional or currently represent payor/provider contracts with limited to no downside risk (i.e. providers not yet truly at-risk for patient panel).
- Regardless of the speed at which ACOs become the new paradigm – or whether ACOs even succeed at all – **it is clear that the market is moving towards providers taking on more risk**.
- **Public health – leveraging this significant state executive branch tool – is uniquely situated to create incentive for population health management** that will allow health systems to play an active role in addressing the Social Determinants of Health.

DoN Health Priorities:
Impacting the Social Determinants of Health



Frieden T. American Journal of Public Health | April 2010, Vol 100, No. 4

- The environments in which we live, work, learn, and play have an enormous impact on our health. Re-shaping people's physical, social, economic, and service environments can help ensure opportunities for health and encourage healthy behaviors; however, **we currently allocate the fewest resources to influencing these factors**.
- For systems to successfully take on more risk (i.e. value-based health care), **systems will need to develop an expertise and focus on population health**, *both* at the patient panel level, as well as at the community level (e.g. understanding how mental health, substance abuse, housing, environment, and other community-level factors impact their patient panel's outcomes).
- DoN can help create capacity for systems of care to bridge to this new reality.

How do we build a bridge between health care and public health through DoN?

CHI Today:

- ❑ No coordinated disbursement of the more than $170M in CHI investments committed between FY06 through FY16;
- ❑ No standardized documentation or evaluation to ensure spending directly contributes to increased health outcomes and lowered THCE;
- ❑ Not consistently publicly planned or competitively procured with unclear DPH role;
- ❑ Flexible community engagement standards;
- ❑ Often small, uncoordinated investments across many issue areas;
- ❑ Does not fully leverage DPH's ability to build population health expertise across health care system, failing to incentivize providers' adoption of population health strategies *both* at the patient panel level and community level needed to successfully take on desired risk.

CHI Tomorrow:

- ❑ Standardized, coordinated CHI investments with enhanced accountability and reporting, ensuring critical dollars are contributing to the improvement of community health;
- ❑ Strong community involvement with funds disbursed through a transparent process from provider organizations with final DPH approval;
- ❑ Clear community engagement expectations that set "gold standard" for community-based planning;
- ❑ Larger and/or coordinated approaches to CHI investments that ensures targeted investments with high-value returns across a community;
- ❑ Establishes a public health framework that will allow DPH to support a social determinant of health and health equity approach to community health investments. This approach will balance investments in both state "Health Priorities" as well as targeting resources towards responding to individual Community Health Needs Assessments and identified local health disparities.

Current CHI: Does not require alignment of CHI planning with state AGO and federally mandated community benefits processes

Federally Mandated

Community Health Improvement Planning (3 year cycle)

1. Assess & prioritize local health needs
2. Engage community and key local stakeholders to identify evidence based interventions

OUTPUT

- List of priority community health needs
- List of selected interventions

Lack of Synergy

- Many similar health needs assessments are occurring with no alignment
- The same stakeholders are being approached separately for the CHIP vs DoN processes

- Separate health priorities are identified
- Separate evidence based interventions are proposed and selected

Current DoN/CHI Planning

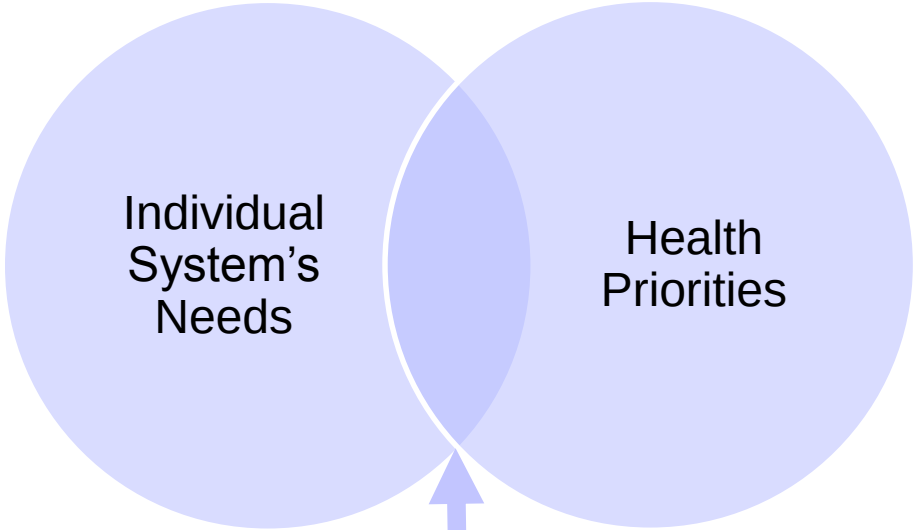
1. Assess & prioritize local health needs
2. Engage community and key local stakeholders to identify evidence based interventions

OUTPUT

- List of priority community health needs
- List of selected interventions

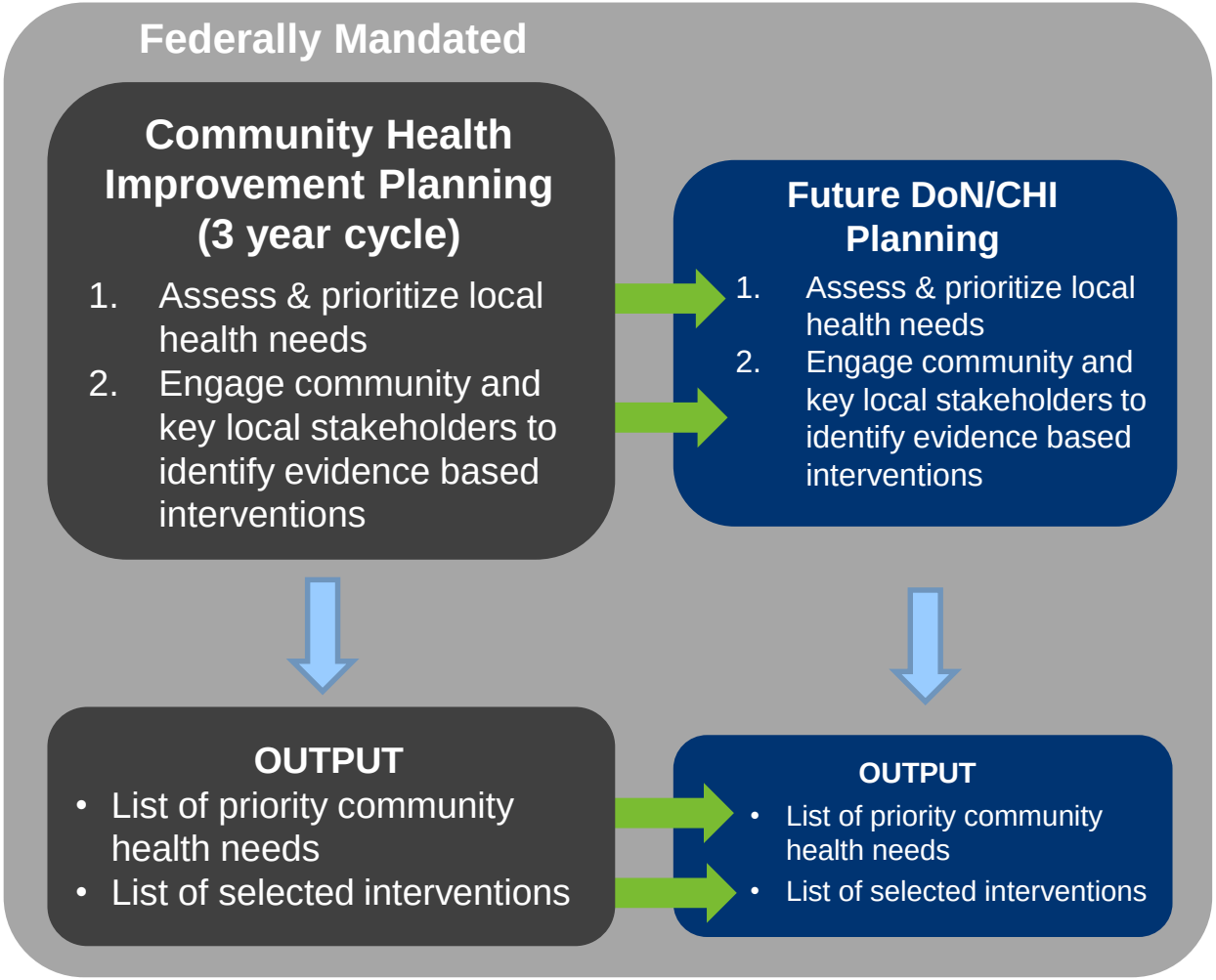
What is Government's Role?

DPH's role is balancing these two perspectives: needs of individual systems of care and the state's health priorities. This role reflects DPH's mission.



- **Individual System's Needs**: Applicants can best demonstrate the *Triple Aim* (IHI model): 1) need within their system by their patients, 2) competitive price, and 3) demonstrable "public health value".
- **Health Priorities**: DPH establishes executive branch "Health Priorities" based on the underlying social determinants of health that drive health outcomes, inequity, and costs.
- **DoN Role**: The question for public health becomes how proposed projects address and balance both a system's needs and the broader communities responses to the underlying social determinants of health – the "Health Priorities".

CHI from a System Transformation Approach: Collaboration and true alignment between ongoing state AGO and federally mandated community benefits processes and CHI will:

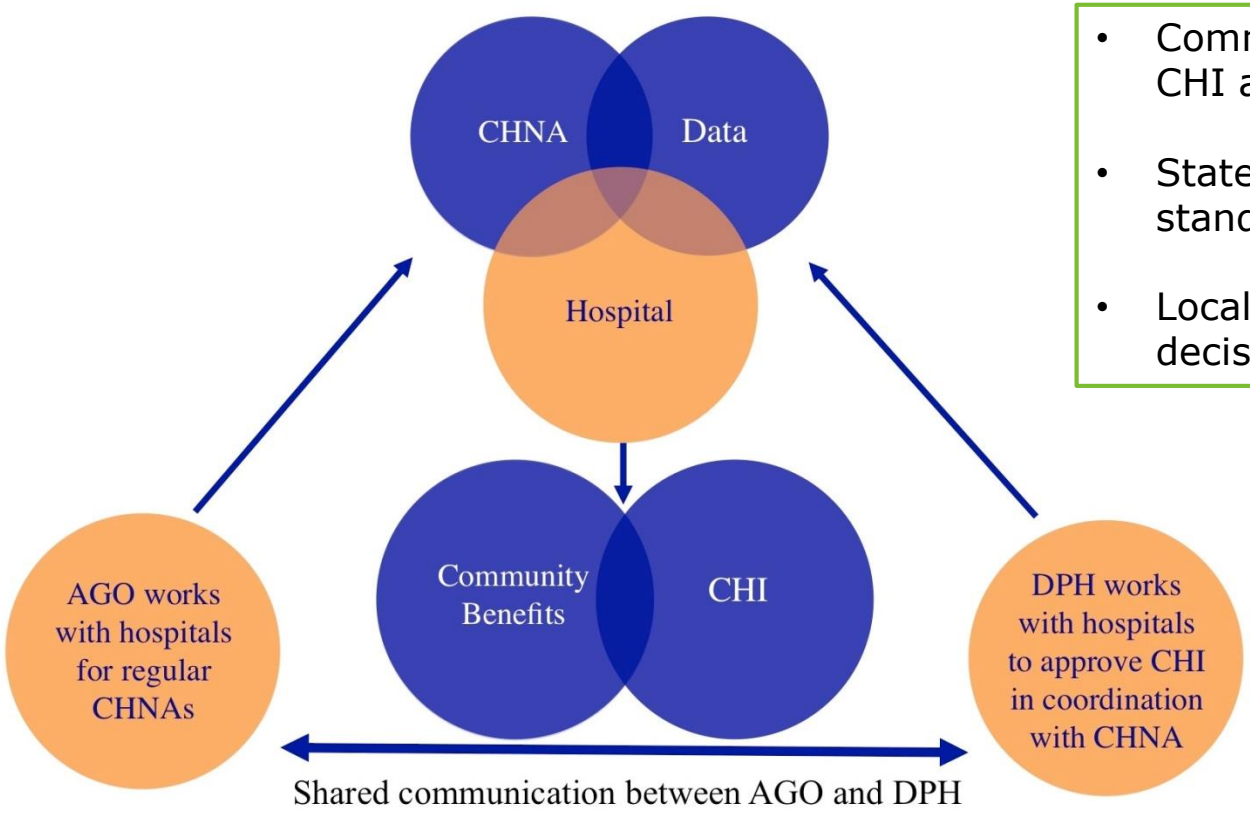


New Synergies

- Provide opportunities to leverage existing community needs assessments
- Minimize duplication of stakeholder engagement efforts
- Standardize definitions, approaches, and evaluation of community engagement

- Identify potential alignment of priority health needs
- Select similar, or complimentary interventions
- Leverage joint resources for larger community impact

CHI from a System Transformation Approach



New Synergies and Bigger Impact

- Community Benefits and CHI alignment
- State defined minimum standards
- Locally led and local decision-making

Health Priorities: *Impacting the Social Determinants of Health*

Based on a comprehensive review process, the following DoN Health Priorities were selected:

- ❑ **Socio-Cultural Environment**
- ❑ **Built/Physical Environment**
- ❑ **Housing**
- ❑ **Violence and Trauma**
- ❑ **Employment**
- ❑ **Education**

These Health Priorities:

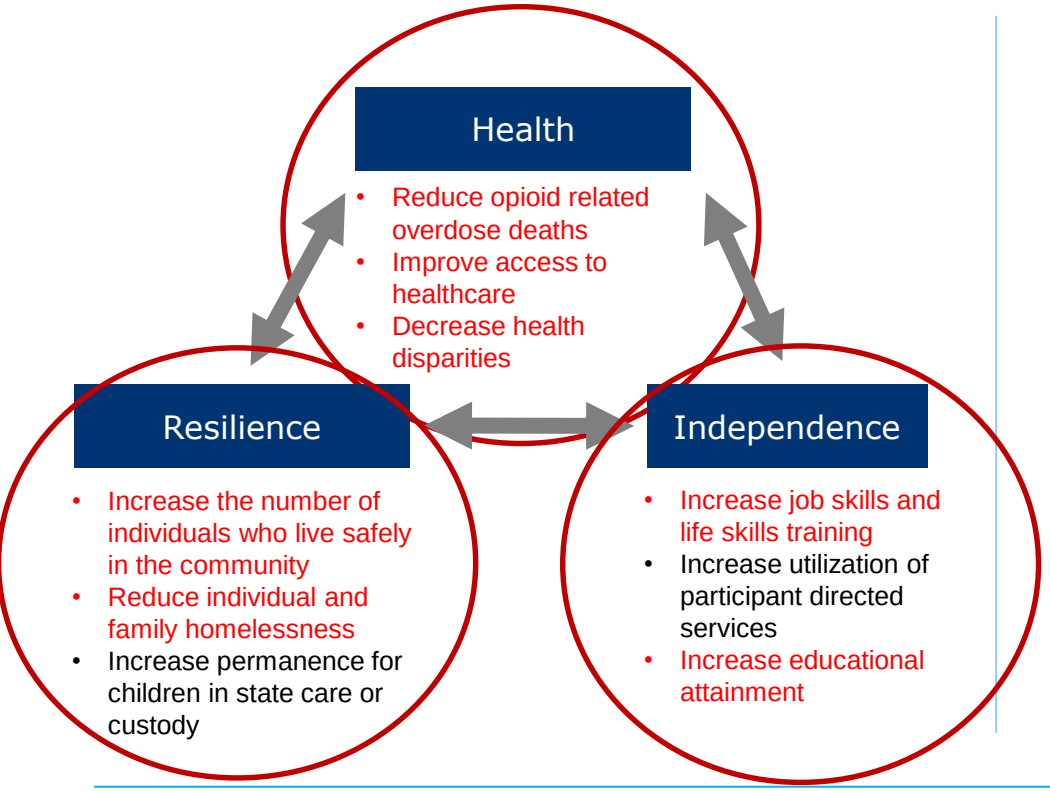
1) Set a long-term framework built around issues that will not change in the short-term;
2) Support successful transition to greater risk;
3) Support the state's current health and human services priorities;
4) Allow for greater collaboration and synchronization of investments regionally/statewide; and,
5) Encompass critical, ongoing community-based work.

*Social Determinant of Health framework and definitions are based on the report: Countering the Production of Inequities: A Framework of Emerging Systems to Achieve an Equitable Culture of Health. Available at: http://preventioninstitute.wixsite.com/producingequity

DoN Health Priorities: *Current Issue Focus*

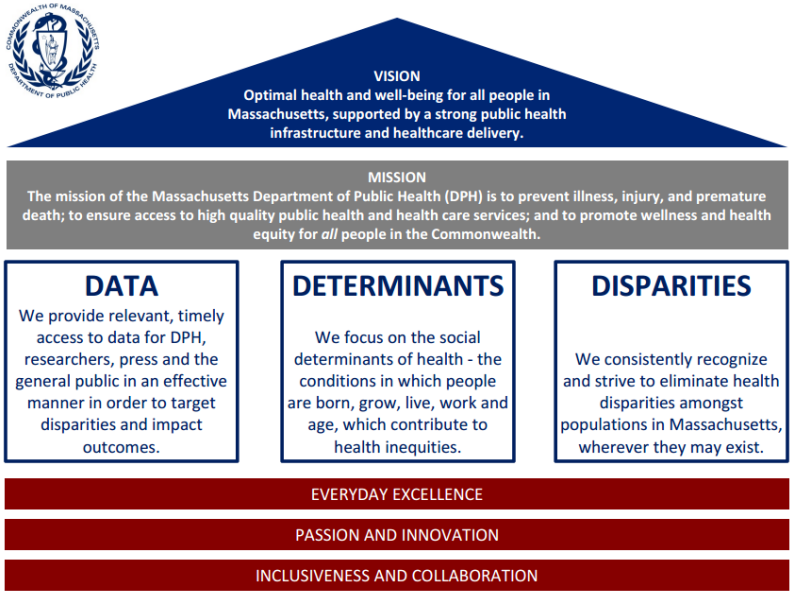
- ❑ DPH considers the six (6) Health Priorities as the structural framework within which specific evidence-informed strategies live and evolve based on funding decisions made by health care systems and their partners through an analysis of current trends, issues, and opportunities for alignment across state and local initiatives.
- ❑ As DPH looks to launch the first iteration of this new approach, strategies to impact and address the Health Priorities will include but not be limited to strategies that directly align and emphasize EOHHS goals of:

Massachusetts EOHHS Priorities



Department of Public Health Priorities

DPH will support DoN Applicants and community partners with new data tools



DoN Health Priorities: *Current Issue Focus*

Accordingly, and consistent with the stated EOHHS/DPH Priorities, the following **four (4) Issue Priorities** are included in the Health Priorities Guideline.

1) Substance use disorders (SUDs)
2) Housing Stability/Homelessness
3) Mental health and wellness
4) Chronic disease with a focus on Cancer, Heart Disease and Diabetes

These issues are:

1. Trending negatively,
2. Represent issues that are driving mortality/morbidity and health care cost, and
3. Are either a social determinant of health (e.g. housing stability/homelessness) or are issues that are sustainably addressed using a social determinant of health approach (e.g. prevention of heart disease and diabetes requires addressing opportunities for physical activity and access to healthy food).

DoN Health Priorities:
Selecting Strategies that Impact the Social Determinants of Health

1. Impact on Health Priorities	2. Evidence	3. Bucket of Prevention*	4. Strategy Feasibility & Impact
☐ One or more	☐ One or more	☐ One or more	☐ Account for all
☐ Logic model/causal pathway	☐ Proven (evidence-informed)	☐ Innovative Community/Clinical Linkage	☐ Reach
☐ Literature/evidence documenting impact of strategy on SDH(s)	☐ Prove It (evidence-based)	☐ Total Population or Community-Wide Prevention	☐ Population/community to be impacted
			☐ Political will/community support

* Auerbach, John. "The 3 buckets of prevention." *Journal of Public Health Management and Practice* 22.3 (2016): 215-218.

DoN Health Priorities: *Future DoN investments will remain consistent with the current DoN focus on community-based strategies*

Patient Approaches	Innovative Community-Clinical Linkages	Policy/Environmental and/or Community Wide Strategies
Asthma NEAPP Guidelines-Based Care • Establish an Asthma Registry • Access asthma severity for all asthma patients • Provide an Asthma Action Plan for all asthma patients • Appropriately prescribe inhaled corticosteroids for all patients with persistent asthma • Encourage all asthma patients to get a flu vaccine • Assess all asthma patients for tobacco smoke exposure and refer to cessation services as needed • Assess asthma control for all asthma patients • Review medications, technique, and adherence at each follow-up visit • Recommend ways to control exposures to allergens, irritants, and pollutants that make asthma worse	• Provide CHW-led multi-trigger, multi-component asthma home visiting for high-risk patients which address both asthma management and environmental trigger remediation. • Provide low-cost supplies that reduce asthma triggers in the home (e.g, HEPA vacuum cleaners, mattress covers) and educate families on how to use supplies • Provide comprehensive school and Head Start-based asthma programs which address asthma education, case management and environmental/indoor air quality issues 	• Provide support to private and public housing landlords and property managers interested in adopting a smoke-free rule in multi-unit housing • Enforce anti-idling and school IPM laws • Promote school Indoor Air Quality through the Promoting Policies for Asthma in Local Communities (PALC) Schools initiative • Promote Integrated Pest Management through the PALC IPM initiative 

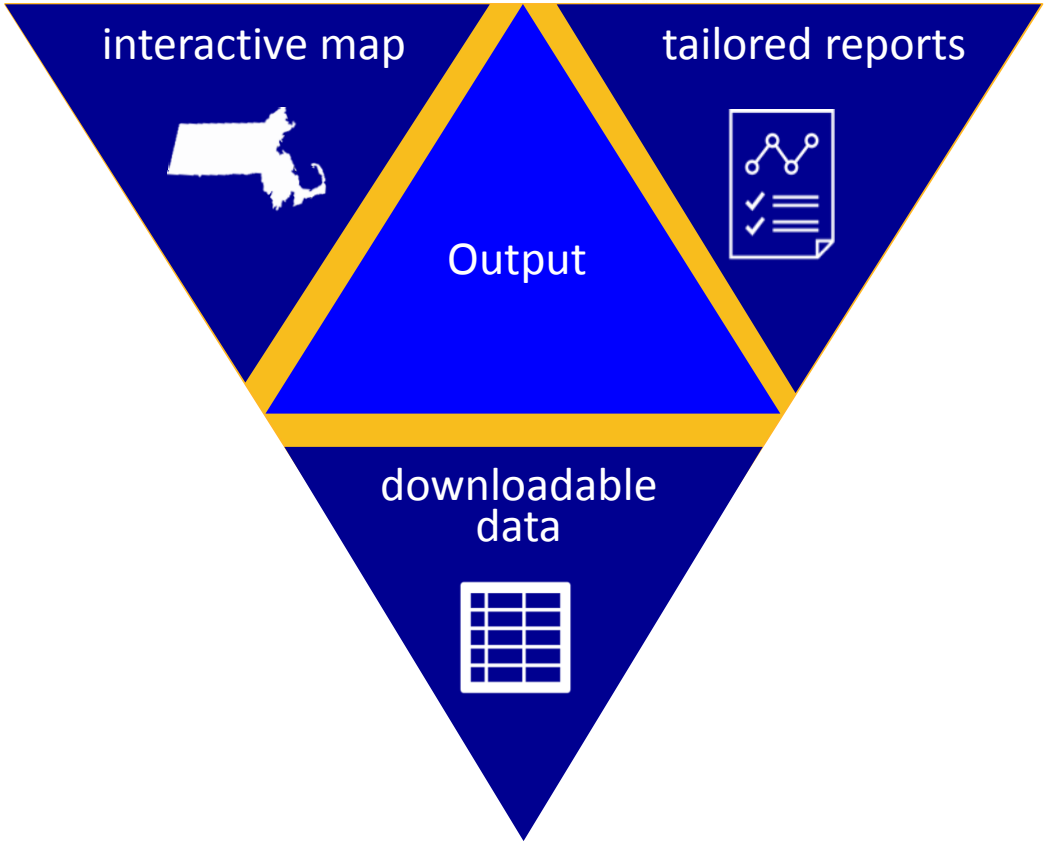
*Based on the CDC's framework of the 3 Buckets of Prevention, 6/18 Initiative and HI-5 found at www.cdc.gov/policy

Summary of CHI Changes

- CHIs will establish a public health framework allowing DPH to support a social determinant of health and health equity approach to community health investments. This approach will balance investments in both state "Health Priorities" as well as targeting resources towards responding to local CHNAs and identified local health disparities.
- DPH will now have a role in how the community is engaged and how data and information are used in CHNA/CHIP processes creating opportunity for aligning community benefits determinations with the types of strategies funded through CHIs.
- Through guidelines developed by DPH, CHIs (and by association CHNA/CHIPs) will have to meet community engagement standards.
- CHI changes support the rationale and operation of a new CHI Statewide Initiative supporting coordinated local CHIP efforts, system wide evaluation and resource support to underserved areas of the Commonwealth.


PHIT
Population Health Information Tool

Population Health Information Tool (PHIT): *DPH's new tool for Community Health Needs Assessments*



Population Health Information Tool (PHIT): *Tailored Reports Consistent with the DoN Health Priorities*

Six (6) reports for each community containing:

1. Description of the Social Determinant of Health (SDH)/DoN Health Priority
2. Measures of the SDH
3. How the SDH impacts health
4. Health behaviors associated with SDH
5. Health outcomes associated with SDH

❖ *Explicit reference to health equity throughout*

Population Health Information Tool (PHIT): *Tailored Reports Consistent with the DoN Health Priorities (Employment Mock-Up)*

Population Health Information Tool
Community Employment Profile for:

Employment in Examplefield

Employment is the availability of safe, stable, quality, well-compensated work for all people.[1] Employment, including the conditions of work that people are engaged in, effect health in a number of ways. In order to understand how employment impacts health within your community, it is important to know whether community members are working or not and the nature of work that those who are employed are doing. Looking at this by demographic characteristics can provide important insights about health inequities. The available employment data in PHIT is grouped into the following categories:

Workplace Risk Factors
For those who are employed, working conditions can pose health and safety risk or support healthy activities and behaviors. Workplace hazards include chemical and physical factors in the workplace that increase risk of traumatic injury or illnesses. Working people's exposure to job related hazards and benefits is also dependent on the industries where they work and their occupations.

Work-related resources and work-life balance
Supportive work environments can promote healthy activities and choices. Resources and opportunities made available to people through their jobs also impact health. In addition to income, these can include health insurance, sick and personal leave, child and elder care services, and wellness programs that can impact the health and wellbeing not only of workers but their families. Among those working , low-wage workers, especially immigrants, minorities tend to be disproportionately employed in physically demanding, high risk jobs with high psychological stress – those that offer little opportunity to influence how or when they work and less access to job-related resources .[1,2,3]

Employment status
Employment provides income, often other economic benefits and, for many, a sense of meaning as well as social support.[4] On the other hand, unemployment is associated with many measures of poor health. The adverse consequences of unemployment and high risk work environments are not borne equally. Racial and ethnic minorities are more likely to be unemployed.

Characterization of Work
The organization of the workplace itself such as shift work, long work hours, and jobs with high demand, low control and poor social support can have direct adverse effects on health through stress related mechanisms. Work organization factors can also indirectly affect health by negatively influencing health behaviors – such as eating habits, sleep, and leisure time exercise.[5,6]

[1] Baron SL, Beard S, Davis LK, Delp L, Forst L, Kidd-Taylor A, Liebman AK, Linnan L, Punnett L, Welch LS. Promoting integrated approaches to reducing health inequities among low-income workers: applying a social ecological framework. Am J Ind Med. 2014 May;57(5):539-56. doi: 10.1002/ajim.22174. Epub 2013 Mar 26.
[2] Massachusetts Department of Public Health. 2010. Health of Massachusetts. Boston: Massachusetts. Available at www.mass.gov/dph/healthofmassachusetts.
[3] Massachusetts Department of Public Health, Occupational Health Surveillance Program (2017). Young Workers Project. Work-Related Injuries to Teens in Massachusetts, 2009-2013 Fatal Occupational Injuries in Massachusetts, 2008 – 2013. Available at http://www.mass.gov/eohhs/docs/dph/occupational-health/18-and-under/teen-work-injury-update-16.pdf
[4] Employment - Why Is Employment Important to Health?. *County Health Rankings*. (2016) Retrieved from: http://www.countyhealthrankings.org/our-approach/health-factors/employment
[4] Waddell G, Burton AK. (2006). Is work good for your health and well-being? Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-foryou.pdf
[5] Hurrell, Joseph J., Jr. "Occupational Stress." Ed. Barry S. Levy, David H. Wegman, Sherry L. Baron, and Rosemary K. Sokas. Occupational and Environmental Health: Recognizing and Preventing Disease and Injury. 6th ed. New York: Oxford UP, 2011. 296-312.
[6] Nobrega S, Champagne N, Abreu M, et al. Obesity/overweight and the role of working conditions: A qualitative, participatory investigation. Health Promotion Practice (MS HPP-14-0219.R2, accepted 2015).

Population Health Information Tool
Community Employment Profile for:

Employment in Examplefield

Employment Status

When people are unable to secure a job altogether, they experience unemployment. Unemployment is associated with poor health, including increased **stress**, **hypertension**, **heart disease**, **stroke**, **arthritis**, and **depression**, and the unemployed population experiences higher **mortality rates** than the employed.[7] Racial and ethnic minorities are more likely to experience unemployment. Moreover, unemployment can lead to homelessness, which has additional negative health consequences (see *Housing* for more information). It is also important to note that employment and education are undeniably intertwined, with education providing opportunities for people to obtain safe, quality, and fairly compensated work (see *Education* for more information).[8] **Accordingly, increasing employment is an Executive Office of Health and Human Services issue priority (increasing job skills and life skills training).**

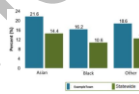
Labor Force Participation Rate

Percent of population 16 years and over who are either employed or actively seeking work
Data sources: American Community Survey, Bureau of Labor Statistics

Your community's labor force participation rate is a metric to assess the proportion of your population who is either employed or looking for work. If the labor force participation rate is low for those under the age of 65, it is important to understand why these

Unemployment Rate

Exampletown: **7%**
Statewides: 6.5%



Percent of population 16 years and over in labor force that are unemployed; civilian labor force unemployment rate
Data sources: American Community Survey, Bureau of Labor Statistics

Your community's unemployment rate tells you of those who are in the labor force, what percentage are working. It is important to consider how this number differs by race and ethnicity to understand disparities in employment opportunities.

[7] How does Employment--or Unemployment--Affect Health? (2013). Health Policy Snapshot Public Health and Prevention. *Robert Wood Johnson Foundation*. Retrieved from: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360
[8] Why Does Education Matter So Much to Health? (2013). *Robert Wood Johnson Foundation*. Retrieved from: http://www.rwjf.org/en/library/research/2012/12/why-does-education-matter-so-much-to-health-.html

Unemployment Rate Geography

Exploring unemployment in different areas can help to identify, which parts of your community need the most attention to increase employment opportunities.

Strategies to Address Employment Status
There may be a need to focus on *strategies that improve employment rates*. For example, **vocational training for adults** supports acquisition of job-specific skills through education, certification programs, or on-the-job training.

Programs may include training and assistance in job searches, personal development resources, and other comprehensive support services (e.g., child care during training). Some programs provide participants with financial compensation for the duration of their participation. Additionally, development of the Community Health Worker workforce is an area that shows promise at impacting employment both directly and indirectly.

Expected benefits of vocational training for adults include increased employment and increased earnings, and other potential benefits include reduced recidivism. Moreover, this strategy is likely to decrease disparities.[1]

When considering options to address unemployment, it is necessary to think about them within the worker to employment pipeline. To fully explore these issues, its best to ensure cross-sectorial collaboration.

Population Health Information Tool (PHIT): *Tailored Reports Consistent with the DoN Health Priorities (Employment Mock-Up)*

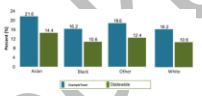
Population Health Information Tool
Community Employment Profile for:

Employment in Examplefield

Employment and Health Equity

Racial and ethnic minorities are more likely than non-Hispanic whites to earn less income, live in poverty, and experience unemployment. As a result, they have higher rates of poor health outcomes and mortality.[15,16,17,18,19] When employed, racial and ethnic minorities are also more likely to be employed in more hazardous jobs Unable to access safe, high-paying jobs, these communities also make up a substantial portion of the "working poor."[20] The working poor are at a disadvantage with respect to many elements of employment (e.g., their jobs are less likely to pay well and/or offer health insurance and other benefits and are more likely to put them at risk of exposure to occupational hazards), thus contributing to health disparities. Consequently, investing in employment is a matter of health equity.

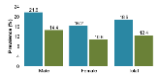
Employed Persons by Race



Percent of population 16 years and over who are employed by Race

Data sources: American Community Survey, Bureau of Labor Statistics

Employed Persons by Gender



Percent of population 16 years and over who are

[15] Woolf S and Braveman P. "Where Disparities Begin: the Role Of Social And Economic Determinants – And Why Current Policies May Make Matters Worse." Health Affairs 30, no. 10 (2011): 1852-1859.
[16] Hahn R, Eaker E, Barker N, Teutsch S, Sosniak W, Krieger N. "Poverty and Death in the United States – 1973 and 1991." Epidemiology 1995; 6: 490-497.
[17] VCU Center on Human Needs. "Project on Societal Distress – Income in the United States." October 2010 Robert Wood Johnson Foundation (RWJF). "Issue Brief #1: Exploring the Social Determinants of Health: What Shapes Health-Related Behaviors?" March 2011
[18] Centers for Disease Control and Prevention. "CDC Health Disparities and Inequalities Report – United States, 2013." Morbidity and Mortality Weekly Report. November 2013
[19] Employment - Why Is Employment Important to Health?. *County Health Rankings*. Retrieved from: http://www.countyhealthrankings.org/our-approach/health-factors/employment
[20] Wicks-Lim, Jeannette (2012). The Working Poor A Booming Demographic. *New Labor Forum*. 21(3): 17-25. Retrieved from: http://nlf.sagepub.com.ezproxy.bu.edu/content/21/3/17.full.pdf+html

Population Health Information Tool
Community Employment Profile for:

Employment in Examplefield

Health Behaviors Associated with Employment

Employment has been shown to impact the following health behaviors. While our data sources do not provide sufficient sample sizes for Examplefield's industry-specific health behavior estimates, for all of Examplefield's 18+ population, the Department's Small Area Estimates following health behaviors are as follows. *For more information on the methods used to estimate these health behaviors please see here.*

Indicator	Examplefield	Massachusetts
Alcohol Consumption	Worse than the state	60.4% (95% CI: 58.9-61.8)
Fruit/Vegetable Consumption	Better than the state	66.0% (95% CI: 64.6-67.5)
Any exercise in the last 30 days	Not Statistically Different	73.5% (95% CI: 72.1-74.9)
Smoking	Worse than the state	14.0% (95% CI: 13.0-15.0)

These are small area estimates from the Behavioral Risk Factors Surveillance System. The methods for developing these estimates are found here.

*This is not an exhaustive list. Click **here** to see more health behaviors for your community.

Health Outcomes Associated with Employment

		Compared to
Stress ? *(indicator not yet selected)*		MA Counties; MA Value (132.7); Prior Value (176.9); Trend
Hypertension *(indicator not yet selected)*	14.4 Deaths per 100,000 population (2012)	MA Counties; MA Value (6.6); Prior Value (6.6); Trend
Cardiovascular Disease *(indicator not yet selected)*	23.2 Deaths per 100,000 population (2012)	MA Counties; MA Value (6.6); Prior Value (6.6); Trend
Stroke (Casemix) *(indicator not yet selected)*	23.2 Deaths per 100,000 population (2012)	COMPARED TO: MA Counties; MA Value (5.3); Prior Value (6.6); Trend
Arthritis ? *(indicator not yet selected)*		MA Counties; MA Value (132.7); Prior Value (176.9); Trend
Ever diagnosed with depression (BRFSS)		COMPARED TO: MA Counties; MA Value (5.3); Prior Value (6.6); Trend
Age-Sex Adjusted All-Cause Mortality Rate *(indicator not yet selected)*	14.4 Deaths per 100,000 population (2012)	COMPARED TO: MA Counties; MA Value (5.3); Prior Value (6.6); Trend

Process

- DPH's DoN reform was informed by a comprehensive year-long review and robust public engagement process.
  - ✓ Eight (8) statewide public meetings;
  - ✓ Three (3) opportunities for public comment on the regulations and the accompanying guidelines;
  - ✓ Over 200 meetings and interviews with stakeholders, sister agencies, and content experts ranging from members and staff of the state legislature, local public health departments, community coalitions, and leading health care academics, to architectural and legal firms, public health advocates, health systems, payors, physicians, nursing homes, and freestanding ambulatory surgery centers; and,
  - ✓ Over 3,500 staff hours.

Summary

- **Significantly streamlines and simplifies DoN regulations** (reduces regulation by 50%), reduces administrative burdens, makes common-sense reforms, and enhances cross-agency collaboration and coordination;
- **Modernizes DoN** to reflect today's health care market by incentivizing value-based, population health-driven competition;
- **Increases transparency and objectivity** by insisting on real community engagement;
- **Adds true accountability** by requiring post-approval reporting on public promises made by DoN applicants;
- **Drives community investments towards the social determinants of health**;
- **Meaningfully infuses public health into DoN**, supporting successful health care reform and provider transitions to greater risk.

Thank you!

Commissioner Monica Bharel, MD, MPH

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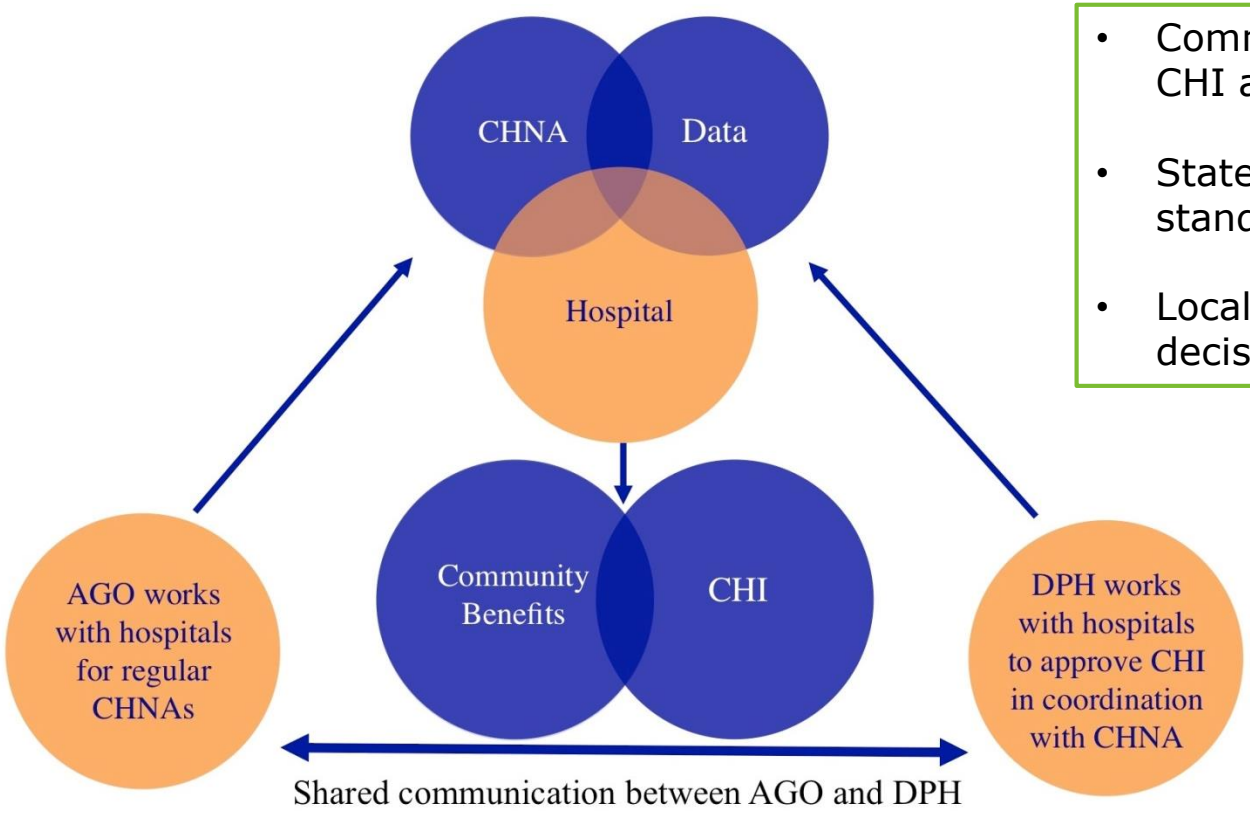
CHI from a System Transformation Approach



New Synergies and Bigger Impact

- Community Benefits and CHI alignment
- State defined minimum standards
- Locally led and local decision-making

Agenda

1. Advisory Task Force Goals & Process
2. Presentation on DPH's CHI Program, Including Updated Health Priorities
3. Discussion of Role of AGO Guidelines in Encouraging Meaningful, High Impact Investments in Documented Health Priorities

Discussion Questions

- How do we best approach standards for meaningful, high impact investments in social determinants of health?
- How can DPH's six health priorities be helpful in the Community Health Needs Assessment process? In filers' processes for developing and funding responsive programs?
- Is the term "Community Building" from the IRS helpful in assessing needs or reporting on investments related to social determinants? Why or why not?
- What are other points in the updated DoN process that present opportunities for alignment with Community Benefits?

Useful Information

Next meeting: Wednesday, June 28th, 2-4 pm
Conference Rooms 2 & 3
21st Floor, One Ashburton Place
Boston, MA 02108

Topic: Potential for Improved Coordination Among Filers and Regional Collaboration

Questions? Contact Project Manager
Elana Brochin at (617) 963-2387